Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin North East
CATCHMENT	Dublin North Central (Mater Sector)
MENTAL HEALTH SERVICE	Dublin North Central (Mater Sector)
APPROVED CENTRE	Acute Psychiatric Unit, St. Aloysius Ward
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	St. Aloysius
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	15
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	10 July 2008

PART ONE: QUALITY OF CARE AND TREATMENT SECTION 51 (1)(b)(i) MENTAL HEALTH ACT 2001

INTRODUCTION

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

St. Aloysius Ward was a 15-bed acute unit. There was one service (Mater sector, population approximately 30,000) with two psychiatrists and a separate service with one liaison psychiatrist and one academic psychiatrist. A social worker and occupational therapist were part of the Mater sector team but there is no psychologist.

The location of the unit was unsuitable: in order to gain access residents, staff and visitors pass by the hospital kitchen area and then must use an intercom to pass through St. Bernard's Ward. On the day of inspection, this area of the corridor had a number of catering trolleys left in the middle of the corridor, which was difficult to negotiate. The unit itself was small and without an observation area. Construction work was still not complete, resulting in noise and disturbance for residents. Despite the decision to incorporate a new unit to replace the unsuitable admission unit in the Mater and to also incorporate the admission unit in St. Vincent's Hospital, there was no plan available and senior management were unaware whether this build was to be part of Phase 1, 2 or 3 of the new construction. Difficulties outlined in the integration of the service provided by St. Vincent's Hospital and the Mater continue: lack of a central referral point, absence of an observation area in St. Aloysius ward, lack of communication concerning care planning, lack of knowledge about the future of the service. It was subsequently reported that the sub-committee reviewing the brief for the new acute psychiatric unit at the Mater had reconvened and had met to revise the draft submission.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Aloysius	15	13	General Adult teams (10 beds) Liaison/Academic (access to 5 beds)

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Each resident should have an individual MDT care plan.

Outcome: There had been no progress on this recommendation. The service subsequently stated that a multidisciplinary team would address this issue.

2. A therapeutic programme should be provided, based on the unit and linked to the care plan.

Outcome: There had been no progress on this recommendation. The occupational therapist based on the sector team provided one session per week. The nursing staff facilitated groups in the sitting room when staff were available. There was no dedicated therapeutic group space and the room identified for group activity was used to house gym equipment and a storage area.

3. The outstanding structural work should be completed.

Outcome: Structural work was progressing extremely slowly and remained incomplete, despite assurances in 2007 that this would be speedily completed. The bathrooms and toilet areas were unfinished and unfit for purpose. They were not wheelchair accessible.

4. The sector team should be located in a single sector headquarters.

Outcome: The CMHN's base was located some distance from the rest of the team. There was no space available in the team building. This problem had persisted over a number of years.

MDT CARE PLANS 2008

It was disappointing to note that no progress had been made and that the timetable of action submitted to the MHC Standards and Quality Assurance Division had long been passed. There was no current action plan to address the deficit. Instructions had been issued from the joint management team to implement care plans as were proposed for St. Vincent's Hospital. However there was no representation from the Mater Hospital at the management meeting. Consequently there was no knowledge of and no ownership of the proposed care plan.

GOOD PRACTICE DEVELOPMENTS 2008

- A number of research projects and audits are ongoing including studies on brain imaging, needs and outcomes of migrants seeking mental health care and an audit of attendances at outpatients.

SERVICE USER INTERVIEWS

No resident asked to speak to the Inspectorate team.

2008 AREAS FOR DEVELOPMENT ON THE QUALITY, CARE AND TREATMENT MENTAL HEALTH ACT 2001 SECTION 51 (b)(i)

1. Detailed plans and timescales for the completion of a new unit in the Mater Hospital must be submitted to the Inspectorate team.

2. The service must be compliant with all the Regulations, Rules and Codes of Practice.

3. Each resident must have an individual care plan as defined in the Regulations.

4. A therapeutic space and programme must be provided. The programme should be based on assessed need and linked to the care plan.

5. Structural work must be completed in a timely way and cause minimal disruption to the residents and staff.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

INTRODUCTION

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the articles in part three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new codes of practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 10 JULY 2008

Article 6 (1-2) Food Safety

The service was compliant.

Compliant: Yes

Article 15: Individual Care Plan

There was no individual care plans as defined in the Regulations. There was no plan to address the breach. Since the inspection, the Inspectorate has been informed that a multidisciplinary team has been set up to develop a care plan. In the meantime, it was stated that the Area 7 care plan had been introduced.

Breach: There was no integrated care plan.

Compliant: No

Article 16: Therapeutic Services and Programmes

The sector team had appointed an occupational therapist and social worker since the last inspection. There was no psychologist on the team. The liaison teams comprised of medical and nursing staff only. Residents had access to the full range of services within the general hospital. The pharmacist attended the ward twice weekly.

There was no programme provided on the ward. It was reported that the occupational therapist provided one group per week. The nursing staff facilitated groups when staff were available. The room identified for group and therapeutic space was used to house gym equipment and laundry facilities.

Breach: There were no therapeutic activities linked to a care plan [Article 16 (1)].

Compliant: No

Article 17: Children's Education

No child had been admitted to the ward since January 2008. There was no provision of appropriate educational services.

Breach: There was no provision of appropriate educational services.

Compliant: No

Article 18: Transfer of Residents

The service had a policy and procedure in place.

Compliant: Yes

Article 19 (1-2): General Health

All residents had access to a full range of services within the general hospital. Two residents were on the ward for a period greater than six months. One resident did not have a six-monthly physical completed.

A policy was in place.

Breach: One six-monthly physical review was not completed [Article 19 (1)(b)].

Compliant: No

Article 20 (1-2): Provision of Information to Residents

There was an information leaflet. Information on the resident's MDT and meal times was missing. It was reported by staff that there was access to the pharmacist and the Internet when providing information on medication and side effects. Information on diagnosis was provided verbally. The Irish Advocacy Network (IAN) visited the ward weekly. Information leaflets and contact details were on display.

Breach: Article 20 (1)(a), Article 20 (1)(b)

Compliant: No

Article 21: Privacy

The service was compliant.

Compliant: Yes

Article 22: Premises

The premises were clean, lit, heated and ventilated. The programme of routine maintenance was ongoing. It appeared to be intermittent, with workmen in the ward on a constant basis.

There were inadequate bathing facilities that were wheelchair accessible. Completion dates submitted to the MHC had not been achieved. Risks had been identified by the risk manager in the shower cubicles but there was no action plan. A statement reporting that work was to commence in August was subsequently submitted as was a risk assessment report.

The premises were located on the ground floor. Due the size, layout and location there were ongoing risks. On the day of the inspection access was through another ward via intercom. It has been reported that a new psychiatric unit for the catchment would be located in the Mater Hospital.

Detailed plans and timescales for completion were not submitted to the Inspectorate team although it was subsequently reported that a subcommittee had been reconvened and had met regarding the new unit.

Breach: Article 22 (3)

Compliant: No

Article 23 (1-2): Ordering, Prescribing, Storing and Administration of Medicines

The service was using the system in place for the Mater Hospital.

Compliant: Yes

Article 26: Staffing

The registered proprietor submitted the recruitment policies for the Mater Hospital.

The nursing staff roster had changed since the last inspection.

STAFF TYPE	DAY	NIGHT
Registered Psychiatric Nurse	CNM2 and 4 staff nurses	3 staff nurses

There were a total of 13.5 whole-time-equivalent nurses available to the ward. The in-patient needs of the Mater sector residents are currently met by one psychiatrist with two sessions and another psychiatrist with three sessions and there was one liaison (0.9 whole-time-equivalent) and one academic psychiatrist. There was an occupational therapist and social worker on the sector team. There was no psychologist based on the team.

An Assistant Director of Nursing was on duty each day and a nursing site manager on duty at night and weekends.

A record of education and training was maintained by the CNM2. All staff had completed training in the Mental Health Act. Copies of the Regulations, Rules and Codes of Practice were available.

Breach: Article 26 (2)

Compliant: No

Article 32: Risk Management Procedures

There was a comprehensive risk management policy and strategy in place for the Mater Hospital. It was not localised to the approved centre.

There was written identification and assessment of risks throughout the ward. There were individual assessments available from the risk manager and fire officer. There was a written plan in place to control the risks identified. All incidents were reported in line with hospital policy. There was a procedure in place for responding to emergencies. All incidents were reported to the MHC in accordance with the Code of Practice.

It was subsequently reported that a safety statement and policies were being developed.

Compliant: Yes

2.3 EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT 2001 SECTION 52 (d)

SECLUSION

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of Seclusion.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	One seclusion order was unsigned.
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Patients were monitored while in seclusion.
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	A number of seclusion periods were not terminated on the seclusion register.
7	**Facilities**	The seclusion room was located in the middle of the ward.
8	**Recording**	The register was not completed in a number of cases. The reasons for seclusion and the alternatives considered were not documented.
9	**Clinical governance**	There was a policy on seclusion.
10	**Staff training**	Staff were trained in control and restraint and de-escalation techniques.
11	**CCTV**	There was a notice outlining the use of seclusion.
12	**Child patients**	No child had been secluded.

Breach: Section 2.5, Section 6.3, Section 7.3, Section 8.2

Compliant: No

ECT

ECT was performed in the minor theatre of the hospital. A detained patient had received ECT and a report was requested by the Inspectorate team.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of ECT.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	There was an adequate consent form available
3	**Information**	There was adequate information available in written format.
4	**Absence of consent**	A detained patient had been given ECT following provision of written consent for ECT while at the same time a Form 16 (4.2 of the Rules) had been completed. On review of the clinical file it was unclear whether the patient had capacity to give consent. There was no up to date record of assessments of this patient's capacity to consent found in the clinical file. The Inspectorate were unable to ascertain whether the patient had capacity to consent to ECT and whether the patient was receiving ECT under Section 59 (a) or 59 (b).
5	**Prescription of ECT**	The prescription of ECT was in order
6	**Patient assessment**	There was no evidence that the patient's cognitive functioning was assessed on an ongoing basis.
7	**Anaesthesia**	Compliant
8	**Administration of ECT**	Compliant
9	**ECT Suite**	ECT was carried out in theatre.
10	**Materials and equipment**	ECT was carried out in theatre.
11	**Staffing**	Compliant
12	**Documentation**	All documentation was present in the file.
13	**ECT during pregnancy**	No pregnant patient was receiving ECT.

Breach: Section 4.1 and Section 6.1

Compliant: No

The service reported that the necessary changes had been made subsequent to the inspection.

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not in use on the ward.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	With regard to a detained patient there was no evidence in the file reviewed that cot sides had been prescribed in accordance with this Rule.

Breach: Part 5

Compliant: No

2.4 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

PHYSICAL RESTRAINT

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of Physical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	One clinical restraint form was unsigned.
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	There was a policy in place.
7	**Staff training**	Compliant
8	**Child residents**	Not applicable

Breach: Section 2.8

Compliant: No

ADMISSION OF CHILDREN

The unit did not meet the requirements of this Code of Practice. It was unsuitable for the admission of children.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Admission of Children under the MHA 2001.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Admission**	Non-compliant
3	**Treatment**	No file was reviewed. There were no children admitted in the current year.
4	**Leave provisions**	No file was reviewed. There were no children admitted in the current year.

Breach: Section 2.5

Compliant: No

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Notification of deaths**	Compliant.
3	**Incident reporting**	Non-compliant with Section 3.1.
4	**Clinical governance**	Non-compliant.

Breach: Section 3.1 and Section 4

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of ECT for Voluntary Patients.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Compliant
3	**Information**	Compliant
4	**Prescription of ECT**	Compliant
5	**Assessment of voluntary patient**	Compliant.
6	**Anaesthesia**	Compliant
7	**Administration of ECT**	Compliant
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	No pregnant resident was in receipt of ECT.

Compliant: Yes

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT (MEDICATION)

Compliant: Not applicable